Common Interventions in Two Single Cases of Cognitive and Psychoanalytic Psychotherapies

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The aim of this study was to examine the interventions used in two nonmanualized psychotherapeutic treatments—one cognitive and one psychoanalytically oriented—; assessing the theoretical framework's pervasiveness in terms of the specificity of the interventions implemented by the psychotherapists. Our purpose was to observe which proportion of the therapists' interventions were directly associated with their theoretical background, and which proportion of them represented common, nonspecific or specific interventions. For this research, 29 sessions from a psychoanalytic psychotherapeutic treatment and 15 sessions from a cognitive psychotherapeutic treatment (both audio-recorded and transcribed), were analyzed. The classifications of psychotherapeutic interventions developed by Roussos, Etchebarne, and Waizmann (2005; Roussos, Waizmann, and Etchebarne, 2003) were used in order to characterize the interventions. Results show that both treatments were highly impregnated by nonspecific interventions. Only an average of 17% of the interventions in the psychoanalytic treatment and a 16% in the cognitive treatment, were specific of the theoretical frameworks.

Keywords: common interventions, specific interventions, non specific interventions

Studying how a psychotherapist carries out a treatment implies the evaluation of numerous and varied actions, that take place within a complex setting, as it is the one displayed in a consulting room. Among the myriad of participating factors in this process, it is possible to identify a group of aspects associated with the therapy's therapeutic-theoretical framework.

The action plan prescribed to be executed by a therapist during a psychotherapeutic treatment is more or less systematized by the theoretical

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model that founds each specific type of treatment. However, as regards the interventions, the level of precision is usually very low (with the exception of manualized treatments, which, nevertheless, continue to represent only a minimum proportion of the existing treatments nowadays). Likewise, the theoretical guidelines that proscribe interventions (i.e., that stipulate which are the interventions that should not be implemented in a specific treatment), have not been developed yet. As a result, it becomes a complex task to discriminate which interventions belong to a specific type of psychotherapy, and which of them do not. This is one of the several obstacles with which clinicians, researchers and theorists are confronted when studying psychotherapeutic interventions. Different strategies have been used in order to analyze them, in both the theoretical development and the empirical field.

Beutler, Machado, and Neufeld (1994) understand the interventions in a psychotherapeutic treatment as the technical procedures designed to promote therapeutic change. In the present study, it will be considered as types of interventions, all of the therapist's actions, within the therapeutic session, which are directed to the patient and have a therapeutic purpose.

The aim of the study presented in this paper was to analyze the interventions used in two nonmanualized psychotherapeutic treatments—one cognitive and one psychoanalytically oriented. The intent was to assess the theoretical framework's pervasiveness in the interventions presented by the psychotherapists. Our purpose was to observe which proportion of the therapists' interventions is directly associated with their theoretical background (i.e., the proportion of specific interventions), which proportion represents nonspecific interventions and which proportion is common to both frameworks.

THERAPISTS' INTERVENTIONS AS NONSPECIFIC OR SPECIFIC FACTORS

At present, there are numerous theoretical and technical discussions in relation to those ingredients that intervene and are active participants in the therapeutic process. Among them, we can find specific and nonspecific common factors, which lead to the conceptualization of specific, nonspecific and common interventions.

Common factors are those factors shared by most psychotherapeutic treatments. Relevant studies, analyzing psychotherapeutic common factors, have been developed by Lambert, Shapiro, and Bergin (1986) and Lambert (1992), which state that common factors seem to be twice more important (30%) than the techniques (15%) in relation to their influence on the psychotherapeutic results.

In search for integrative constructs in the therapeutic process Orlinsky and Howard (1986) designed the "generic model of psychotherapy." This model systematizes the variables of the therapeutic process in five conceptual elements, generic to most psychotherapies.

As for the interventions, we define common interventions as those shared by two or more theoretical frameworks. Along those lines, common interventions can be either specific or nonspecific (Waizmann, Etchebarne, & Roussos, 2004). An example of a common intervention is the "information request" intervention, in which the therapist asks the patient for information about a particular topic in an open ended style (Roussos, Etchebarne, & Waizmann, 2005; Roussos, Waizmann & Etchebarne, 2003).

Nonspecific interventions are those not specifically declared as part of, or theorized by any theoretical framework. This means, that the theory does not define them explicitly as one of its components. An example of a nonspecific intervention is the "anticipation" intervention, in which the therapist anticipates, "guesses" what the patient is about to say (Roussos, Etchebarne & Waizmann, 2005; Roussos, Waizmann & Etchebarne, 2003).

Even though it does not necessarily occur, most of these nonspecific interventions are common to different psychotherapeutic treatments. That is the case of the "demand of further elaboration" intervention, in which the therapist asks the patient to provide a more detailed and thorough description, concerning a particular subject, or simply requests the patient to continue talking about a topic that had been recently mentioned by him/her (Roussos, Etchebarne & Waizmann, 2005; Roussos, Waizmann, & Etchebarne, 2003).

In relation to technical or specific interventions, these are thought as those aspects that are explicitly defined by the theoretical framework. This means that they have been theorized by a specific therapeutic model (Waizmann et al., 2004). An example of a specific intervention from the psychoanalytic theoretical framework is the psychoanalytic interpretation intervention, defined as "formulations oriented to unconscious material, defensive operations, unconsciously excluded instinctive tendencies, hidden meanings related to the patient's behavior patterns" (Wallerstein & DeWitt, 2000). As for a cognitive specific intervention, we can mention the "cognitive rehearsal" intervention, which consists on asking the patient to imagine successively each of the steps that are part of the execution of a task, in the case of cognitive therapy.

The fact that each theoretical framework may theorize certain types of interventions, does not mean that psychotherapists adherent to other theoretical frameworks cannot deliver them throughout a treatment, and still be congruent with their working methodology. This means that the pool of interventions theorized by each theoretical framework does not cover all of the actions carried out by psychotherapists throughout their work. Never-

theless, we have not been able to find any publications that point out the quantity or frequency of the interventions specific of other theoretical models, displayed in habitual psychotherapeutic treatments. The common interventions can either be specific or nonspecific.

Throughout the present paper, we will use the previously presented definitions of specific and nonspecific psychotherapeutic interventions, in order to assess the interventions displayed in a psychoanalytic psychotherapy, and in a cognitive psychotherapy, exclusively. Consequently, in this article we focus solely on the psychoanalytic and cognitive theoretical frameworks. Therefore, those interventions that are not specific of the psychoanalytic or the cognitive theoretical frameworks will be considered as nonspecific interventions, whether or not they might have been specified by other theoretical frameworks, not included in this study.

INTEGRATIONISM IN ARGENTINA

Although the international growth of integrationist movements has been outstanding for more than 20 years ago (Arkowitz, 1989, Alford & Norcross, 1991), in Argentina, only a few groups of psychotherapists have gone ahead with integrative treatments. It is since 2000 that an increment on the quantity and variety of integrationist movements in Argentina is visible (Gómez, 2007). A longitudinal study performed by Muller (2008) shows the growth of the trend toward integration of different theories, in the last few years in this country. This study polled psychotherapists from five different cities, and it showed that, in less than five years, integrationist models have increased from a 26% to a 40%.

This change in the way of going ahead with psychotherapy delivery has been explained in different ways. For example, Gómez (2007) mentions that as a collateral effect of the 2001 Argentinean socioeconomic-crackdown, professionals were forced to extend the range of the treatments they offered, and to incorporate new methodologies to meet the growing demand. From the traditional psychoanalytic long term treatments, the health systems began to ask for new short term goal-oriented psychotherapies. This trend encouraged a greater cooperation among therapists working from different theoretical orientations, as much as a renewed interest in psychotherapy integration.

Likewise, private clinics, by offering treatment programs at premium prices, became a valuable alternative for taking the pressure off of the overloaded public systems, and for providing tailored treatments (Gómez, 2007).

Another way of explaining this transition—both the growth of therapists working with integrative model and the rupture of the psychoanalytic

homogeneity that prevailed in Argentina—lies in a substantial change in the notion of mental health.

INTERVENTIONS AND THEIR RELATION TO THE INTEGRATIVE MODELS

We can find that, traditionally, there are three groups of integration that characterize this movement, which differ from each other (Arkowitz, 1989; Norcross & Grencavage, 1989; Alford & Norcross, 1991). These groups are:

- Technical Eclecticism,
- Theoretical Integration, and
- The Common-Factors approach.

Within the view of the technical eclecticism, and in one of its most extreme stances, we find that which is represented by Lazarus (2005), who sees every intent of theoretical integration as a useless effort. He states that techniques, disregarding theories, are the foundation when planning a psychotherapeutic treatment. The standards for the technical decisions are then based on the concept of therapeutic efficacy, Random Controlled Trials (RCT) being the mainstream.

Theoretical integration, on its part, denotes a synthesis of diverse theoretical systems. The emphasis is put on the integration of theoretical concepts, being the integrated techniques a result of the theoretical synthesis. In this group we can find Wachtel, who integrates the psychoanalytic and behaviorist theories in a metatheoretical model of psychotherapy (Wachtel, 1977).

The common-factors approach puts its focus on the identification of those shared factors that bring-about psychological change in different therapies. The main purpose of this approach is to identify those factors, or combination of factors that come-out to be better predictors or markers of therapeutic change. It centers its efforts around the similarities between different models, instead of working on the existing differences, as other forms of integration do.

It is also viable to think of this latter approach, rather than as a third type of integrative criteria, as an approach that corresponds to another level of analysis; as on its theoretical and technical levels, it is possible to consider common factors like a cornerstone of the other two levels.

It is from this last perspective that the present study has been set, since the search for common factors has, as its main goal, the identification of the

existing similarities even before any integrationist process; just like it is the case of common interventions.

In this sense, it is necessary to evaluate the existing common factors among psychotherapies, before thinking of any type of integrative process.

Once the commonalities have been established, the consideration of convergences and divergences can begin, in order to discuss the possible integration of such specificities. This might take place in both, the technical and the theoretical level, being this the interaction axis between common factors and the other two integrationist stances.

ISSUES CONCERNING THE METHODOLOGY TO ANALYZE INTERVENTIONS

As we mentioned before, the study of the psychotherapeutic interventions implies several difficulties, and demands a variety of research strategies, whether the researcher intends to capture only the quality of the interventions, their sequence, the timing of their presentation, the strategy involved in their use or the interaction among all of these factors.

One of the research strategies used since the beginning of psychotherapy consisted in a reconstruction of the types of interventions that were enunciated throughout a treatment. The clinical psychology field's continued growth, the change of ethical issues concerning research procedures, and the development of new technologies, have enabled the generation of a varied repertoire of strategies for the interventions' classifications.

One of these strategies consists in the development of classificatory intervention schema or scales, with different characteristics, depending on the goals and methodology followed by the researchers that build them.

There is a group of these classifications that has been built based on theoretical literature. Within this group we can mention the work of Fiorini (2000), Sandler, Dare, et al., 1993, and Wallerstein and DeWitt (2000).

Sandler, Dare et al. (1993) classified the psychoanalytic interventions as confrontation, clarification and interpretation. Wallerstein and DeWitt, (2000) developed an exhaustive classification of therapists' interventions, based on two modalities of psychotherapy approaches, expressive and supportive psychoanalytic therapies. In their classification, they included the following interventions: For the expressive psychotherapies; questioning, confrontation, clarification and interpretation; and for the supportive psychotherapies, they mentioned interventions such as actions, need for gratification, among others.

In 1992, Cooper and Bond (as cited in Banon, Evan-Greinier & Bond, 2001; in Bond, Banon, & Grenier, 1998; and in Milbrath et al., 1999) built

the Psychodynamic Intervention Rating Scale (PIRS). According to these authors, very few of the existing therapeutic intervention scales (at that time) were specific about the types of interpretative interventions. They developed the PIRS in such a way that each therapist's utterance could be classified. In addition to that, this scale divides psychotherapeutic interventions in two broad categories: interpretative (transference and defense interpretations) and noninterpretative (acknowledgments, clarifications, questions, therapist associations, reflections, work-enhancing strategies, support strategies, and contractual arrangements).

Tuckett (2003) developed the "Sorrento Grid" to analyze psychoanalytic interventions. According to this author, different psychoanalytic groups often understand core terms in different ways, without noticing it. In order to avoid such overlapping, Tuckett (2003) chose to elude conventional psychoanalytic terminology when naming and defining the different types of interventions (Tuckett, 2003, date of retrieval: August 6th, 2003, p. 1). The purpose of that methodology was to ensure that both, researchers and clinician participants, were analyzing the same event.

Trijsburg and his colleagues; developed the Comprehensive Psychotherapeutic Intervention Rating Scale (CPIRS), for which they defined the interventions operationally and established anchor points to facilitate the rating process. For the interventions' selection, Trijsburg, Frederiks, Gorlee, den Hollander, & Duivenvoorden, 2002; Trijsburg et al., 2004) designed a two-phase plan: First, they conducted a bibliographical revision of the literature published after 1980, searching for questionnaires and classificatory scales. In the second phase, they collected empirical studies that instrumented the questionnaires and classificatory scales found in the first phase.

MACRO AND MICRO ANALYTIC STRATEGIES TO EVALUATE THE INTERVENTIONS

Milbrath et al. (1999) state the existence of two ways that have been generally used to assess therapist interventions: the micro analytic and the macro analytic methods. In the micro analytic method, each intervention is analyzed at the level of a phrase or speaking turn. In the macro analytic method, interventions are analyzed, not in terms of isolated utterances or speaking turns, but in a more global sense, for example, idea units, content units, and so forth. According to Milbrath et al. (1999), the macro analytic method should be more suitable for outcome studies, and the micro analytic method, for process studies.

Each of the two possibilities of analysis present advantages and disadvantages: The micro analytic level permits a higher degree of accuracy in

terms of coverage (every type of intervention will be evaluated), avoiding the loss of information. However, this method of analysis can misguide the researcher, since many interventions cannot be displayed in a single phrase or speaking turn. Thus, it may fail to register more complex procedures such as the psychoanalytic construction, the cognitive restructuring, or the systematic desensitization, for instance. For the analysis of the latter, the macro analytic method seems to be more suitable.

Another disadvantage of the micro analytic method is that it is difficult to implement and it generates detailed information, which is very laborious to process. This does not occur in the case of the macro analytic method. It should be emphasized that, depending on the purpose of the study, either method could be found to be useful or turn to be inadequate.

Furthermore, it is possible to combine both modalities of analysis, which is the method followed in this study.

METHODS

Since our purpose was to analyze the interventions displayed in two psychotherapies within a naturalistic setting, only a few factors were stable between both treatments. Among these, we can mention the therapists' and the patients' gender, the experience of the therapists in their own theoretical framework, and the outcome of both treatments (both treatments were successful). Several factors, however, were not stable (the patients' age, the length of the treatments, the type of treatment in terms of focalized vs. nonfocalized, the diagnosis, etc.). The selection of clinical material with such degree of variability, was based on the idea to focus on the commonalities between both treatments, and not on their differences.

Participant Cases

The psychotherapists' interventions from two psychotherapeutic treatments—one cognitive and one psychoanalytic—were analyzed.

The treatments' characteristics were the following:

Cognitive Treatment

Background of the Case

Luz (pseudonym) was a 27-year-old woman who sought treatment in 2003 due to her feeling constantly anxious and unhappy with her job. She

presented several medical conditions: had lost a lot of weight in a short period of time, had a chronic rush, and a nonregular menstrual period. She had also been diagnosed with an ovarian cystosis, which triggers the patient's inability to get pregnant.

Background of the Therapist

The therapist was a 48-year-old female psychologist that had 25 years of experience, who was a member and trainee of a cognitive training and practice center.

Treatment

The treatment lasted five months, and it consisted of 16 weekly sessions. Six sessions were reprogrammed due to job difficulties and organic problems.

Luz was referred after the first admission interview. During the first session with the assigned therapist, she expressed to feel anxious, irritable, depressed and worried about her skin problems. After this first interview and the evaluation of some tests (STAI, Spilberger, 1980; SCL-90R, Derogatis, 1994), the patient was given a diagnosis of generalized anxiety disorder (F41.1 [300.02]).

At the beginning of treatment, Luz mentioned that she was previously diagnosed with an inflamed fallopian tube, and apparently she was told then that surgery was needed. According to her, doctors told her that one of the risks of her surgery was that it could unable her to become pregnant. Therefore, the patient's anxiety increased and she said that the potential aftermaths of the surgery would be the worst thing that could happen to her.

The possibility of not being able to become pregnant, and the fact that she was unhappy with her job, became the treatment core themes. The therapist helped the patient realize that she worried excessively about things that could happen to her, or things that effectively occurred. However, once she did find a solution to them, she diminished the importance of the problem.

After five months of treatment, the patient's main goals were achieved: her anxiety had decreased, she had found a new job, and she had also become pregnant. Therefore, Luz asked to finish treatment. The therapist considered the treatment to have been successful, even though the preestablished date for the end of treatment had not yet arrived.

Psychoanalytic Psychotherapy

Background of the Case

Maru (pseudonym) was a 20-year-old woman who sought treatment in 1998 because she felt insecure and ashamed of herself. She associated these feelings with her communication difficulties with people and also with the fact that she used to feel tired and bored whenever she spent time with anyone.

Maru used to live with her parents and her two younger brothers in a small town on the suburbs of Buenos Aires. Two years before began treatment, she had moved to the city with a friend in order to study psychology.

Background of the Therapist

The therapist was a female psychologist that had 16 years of experience, who was a member of a psychoanalytical association that provided the community with low-cost psychoanalytic psychotherapeutic treatments.

Treatment

The treatment had a frequency of one session per week over a period of 2 years, within a year of impasse in between. Maru was referred to the therapist after the admission interview in which she was diagnosed with a personality disorder not otherwise specified (F60.9; 301.9).

At the beginning of treatment, the therapist suggested that she should attend twice a week, but due to economic problems, she continued ongoing once per week.

The patient wanted to find herself a job, and to start being independent, so she had some job interviews, but did not do well on them. The therapist told her that they could have a rehearsal of an interview so that she would feel more secure of herself.

In the last session, before the patient went on holidays and the 1-year break began, the patient said that she had learnt many things and that she felt more secure of herself.

After a year, Maru returned to therapy. She had moved in with one of her brothers, she was working, and, at that job, she had met her current boyfriend. However, she did not like her job and was looking for another one.

In the last part of treatment, Maru found another job that she liked, she enjoyed spending time with her boyfriend and continued with her studies. The therapist told the patient that she had changed significantly, and that she could now connect with a positive part of herself. Therefore, when treatment ended, it was considered a successful one.

Materials

For this research, we used the verbatim transcriptions of two psychotherapeutic audio-recorded treatments. The transcriptions were made according to the bases for transcriptions developed by Mergenthaler and Gril (1996). In the cognitive case, the entire treatment was transcribed and analyzed by the judges, and in the psychoanalytic psychotherapy case, a sample of 29 out of 108 sessions from six periods throughout the entire treatment were transcribed and analyzed (see Figure 1). The transcriptions of these sessions were analyzed independently by trained judges, using the

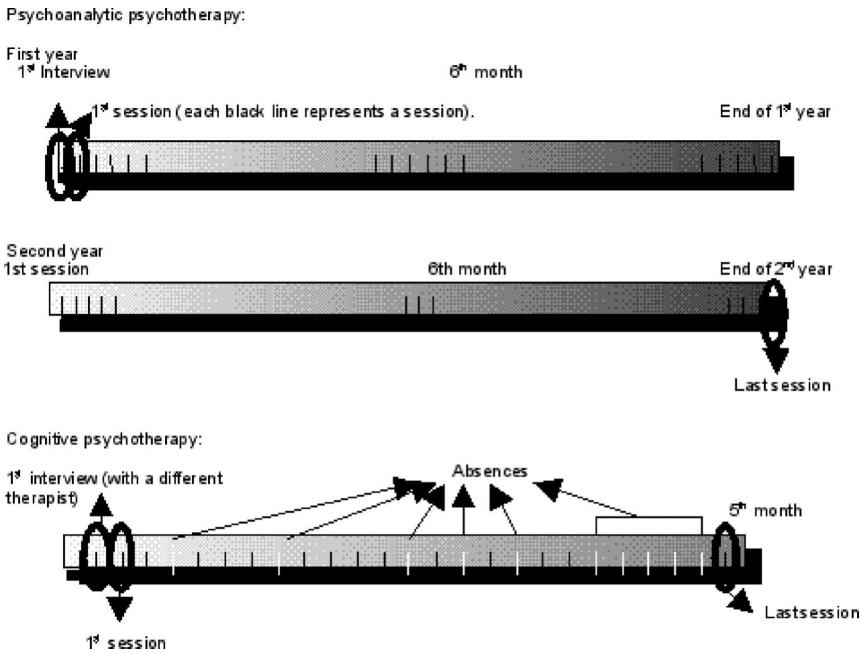

Figure 1. Sessions from one psychoanalytic psychotherapy (29 session, out of 108, were recorded and transcribed, and one cognitive treatment (15 out of 16 sessions were recorded and transcribed).

interventions' classifications designed by Roussos, Etchebarne, and Waizmann (2005) and Roussos, Waizmann, and Etchebarne (2003).

As for the recording of the sessions, the informed consent of the patients, therapists and institutions was obtained.

Description of the Interventions' Classification Schema

Roussos et al. (2005; and Roussos, Waizmann, and Etchebarne, 2003) developed a schema of classifications in order to study the psychotherapeutic interventions implemented in cognitive and psychoanalytic psychotherapies. This schema was developed based on the theoretical and research literature and also on the qualitative analysis of audio-recorded clinical sessions from each of these theoretical frameworks, four levels of analysis of the interventions were considered for the construction of this scheme of classifications: the strategic level, the descriptive level, the content level, and the space-temporal level. These levels of analysis focus on different aspects or variables involved in the act of intervening. Thus, even though the levels of analysis can be used independently, they are not at all exclusive of one another; they represent different aspects of the same event. In the present study has been used only the descriptive level of analysis of the interventions to peruse the interventions; hence, the four levels will be presented, but only this level will be described in depth.

Inspired by Schatch's (as cited in Alford & Beck, 1997) conceptualization of 1984 and Stiles' (1992) conceptualization of 1992, the strategic level is conformed by the purposes or goals pursued by the therapists′ interventions; that is, their rationale (Roussos, Etchebarne, & Waizmann, 2005).

The descriptive level of analysis, also inspired by Stiles' conceptualization, observes the formal characteristics of the interventions made by the therapist. The structure of the intervention is analyzed, regardless of the underlying therapeutic purpose, its content, or the time and space orientation of the intervention. Therefore, for this level of analysis, the interventions are defined in terms of their syntax and morphology.

For example, the confrontation is defined as a subtype of signaling, in which the therapist directs the patients' attention toward contradictory aspects of their manifest thought contents, attitudes, or behaviors; the directives were defined as interventions made by the therapist in such an imposing manner that the patient feels obliged to fulfill them, among others.

In the content level of analysis, the focus is made on the themes included in the interventions (again, regardless of the interventions' structure, purpose or space—temporal orientation). In the space—temporal

level of analysis, the focus is centered on the time and place addressed by the interventions (Roussos, Etchebarne, and Waizmann, 2005; Roussos, Waizmann, and Etchebarne, 2003).

Procedures

The clinical material was obtained from two psychotherapeutic centers (a psychoanalytic association and a private clinic). Beside its belonging to an institutional setting the psychoanalytic candidate recorded the case at her private office, as is usual in her institute, while the cognitive-oriented case was recorded at the clinic. The written and verbal consents were requested from patients, therapists, and center directors.

As for the transcription, the clinical audio recordings were transcribed according to the Mergenthaler and Grill (1996) transcription rules. Once the verbatim transcription of each recorded clinical material was finished, the personal data that could possibly enable the identification of the participants was codified. Then, the interventions were analyzed using the interventions' classifications schema previously described.

For the analysis of the clinical material, three advanced psychology students, without a formal training in psychotherapy techniques, were selected as judges. They were trained in the analysis of interventions with the classificatory schemas, using the sessions' verbatim transcripts from both theoretical frameworks. During the training, for training purposes the judges analyzed interventions in two different ways, individually and in groups. At the end of the training the level of agreement was calculated for the evaluation of both treatments. The descriptive level, which is presented here, showed an intraclass correlation of 0.7 for the psychoanalytic treatment, and an intraclass correlation of 0.65 for the cognitive treatment.

Both the patients' and the therapists' speeches were taken for the analysis of the interventions, and the classification system that corresponds to each psychotherapeutic framework was used in each case.

RESULTS

In Figure 2 it is possible to observe that except for two types of interventions (acknowledgments and close interrogations) the frequencies of interventions considering its type were very similar between both treatments. The percentage of "Information requests" also differed between both treatments, but, in both cases, it was the second mostly used intervention.

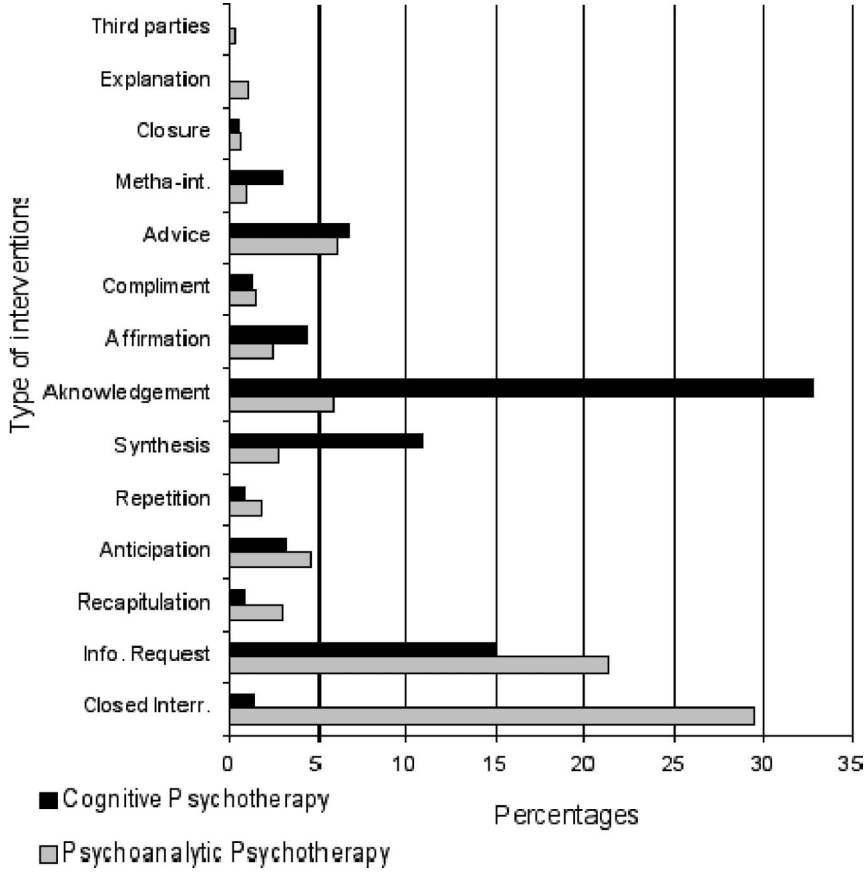

Figure 2. Percentage of nonspecific interventions per treatment.

In Figure 3, it is possible to observe the similarity between the proportional use of specific and the nonspecific interventions in both cases. Figures 4 and 5 show that this proportional distribution of the specific and the nonspecific interventions throughout the treatments was very stable and similar in both cases.

DISCUSSION

The results show that both treatments have been highly embedded with nonspecific interventions (see Figure 3). Only an average of 17% of

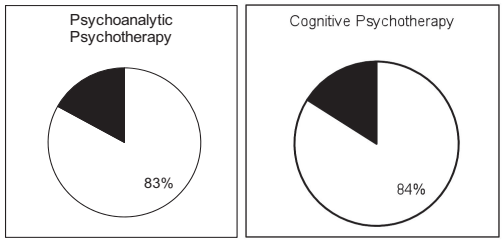

Figure 3. Proportion of specific interventions.

the interventions in the psychoanalytic psychotherapy and a 16% in the cognitive treatment, were specific of each theoretical framework.

The first question opened by this result is whether or not nonmanualized psychotherapeutic treatments, like the two single cases presented herein, have similar proportions of nonspecific interventions. If this result happens to be representative of what occurs in such treatments, then, it would be interesting to discuss about its implications:

- Is this proportion adequate in terms of the theoretical framework and its clinical practice?
- If we consider it to be adequate, does that mean that there could be an optimal proportion of the interventions' specificity? That is, should we find a balance between specific and nonspecific interventions? If that is the case, what could that balance or optimal level be? If at all possible, how could it be assessed?
- Now, if we consider this proportion to be inadequate, what would be adequate, instead? Reducing the type of interventions down to the specific ones? Acting upon the nonspecific interventions and theorizing about them, in such a way that they could be turned into specific interventions? But then again, is it really possible (or useful) to think in terms of "pure" specific treatments? Can we aim or pursue to create psychotherapy with absolutely specified interven-

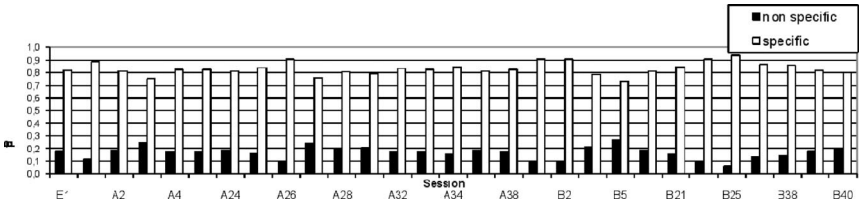

Figure 4. Proportion of specific and nonspecific interventions per session—psychoanalytic psychotherapy case.

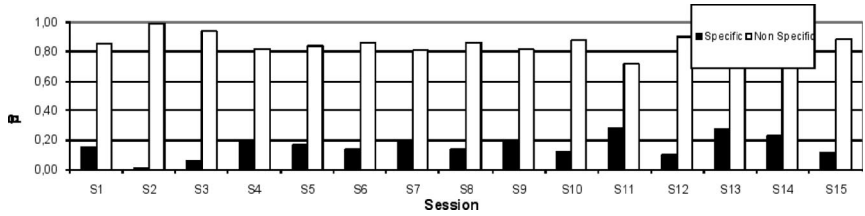

Figure 5. Proportion of specific and nonspecific interventions per session—cognitive case.

tions, regardless of residual not specified interventions? Should we necessarily tend toward a specified psychotherapy? Or is this degree of commonality or uncertainty necessary in order to comprehend the terrain of mid- and long-term, nonfocalized and nonmanualized treatments?

Another peculiarity of the results presented in this paper is that the proportion of specific interventions found in this study is similar to the incidence of the specific factors in patient's improvement, according to the main meta-analysis. Throughout the meta-analytic studies carried-out in the last 30 years, it has already been stated that the incidence of the theoretical framework on the treatment's outcome reaches between a 15% (Lambert, 1992) and an 8%. The results presented in this paper seem to concur with the fact that specific factors only play a limited role in psychotherapeutic outcome or in what characterizes the psychotherapists' actions, represented by their interventions.

Alternative Theoretical and Methodological Understanding

Finding a Place (or Sense) for Nonspecific Interventions

A possible rationale for the differences found in the proportions of nonspecific and specific interventions could be that both types of interventions interact. Taking this assumption under consideration, the nonspecific interventions could be leading the way for the specific ones; that is, their function in psychotherapy could be to generate the right context and timing for the specific interventions. For example, while psychoanalysts are not interpreting, signaling, or confronting their patients, what are they doing? They surely are not in complete abstinent silence all the time. They could be using nonspecific interventions—such as information requests and closed interrogations—to retrieve the necessary input or to "generate" the right moment to perform a precise interpretation (i.e., to generate the right

timing). The same can be said about other types of psychotherapy. Thus, nonspecific interventions could be conceived as "preparatory interventions" for the specific ones, or as part of the natural environment of the specific interventions.

Possible Hypothesis About the Role of Specific and Nonspecific

In the previous paragraph, we stated that nonspecific interventions—a presumably common factor, according to the results that we have presented—could be structured to support and delineate the specific interventions. Extending this hypothesis to the level of the nonspecific and specific factors, it could be rephrased as it follows: Nonspecific factors may come out to be the main promoters of change in psychotherapy, by supporting and delineating the specific factors. According to this hypothesis, we should study nonspecific factors in order to find their links with the specific factors and, through that path, get to, know what characterizes psychotherapy as a promoter of change.

Another hypothesis we would like to discuss is that there could be a constant interaction between nonspecific and specific interventions. Since both types of interventions represent (presumably) a part of the specific and nonspecific factors in psychotherapy, according to this hypothesis, none of these factors (or interventions) would precede the other; on the contrary, both seem to coexist and coparticipate to generate therapeutic change. In addition, they would operate in parallel, complement each other and serve to different functions in different occasions. Therefore, according to this hypothesis, it would not be realistic to study the nonspecific and specific factors in an isolated manner as if they were isolated compartments. The results presented in this paper seem to suggest that following such a research modality would be an inadequate approach of studying nonspecific and specific factors; finding it more suitable to study them as an interactive system.

One of the many limitations of the present study is that only the descriptive level of analysis of the interventions was analyzed. It would be interesting to study—in future research projects—how are psychotherapeutic strategies established (i.e., how are they originated and organized) and what is their relation with specific and nonspecific interventions. We cannot help to wonder whether or not the strategies are a key element to discriminate between specific and nonspecific interventions; that is, to fully understand the specificity of these interventions, should we necessarily study the therapeutic strategies?

The limitation of working with single cases might be the main obstacle at the moment of establishing any type of generalization of the results, but

being the leitmotiv of single-case designs to generate new hypothesis, it is necessary to develop new studies to test these hypothesis on how the interaction between specific and nonspecific interventions takes place.

The Integration of Techniques and Theories, or the Development of an Architecture for a New Psychological Approach

As it has been mentioned before, there are various stances in relation to the direction in which the synergy among the elements considered by the different integrationist approaches should take place. While some suggest a theoretical-technical integration, others consider that it is only at a technical level that integration gains its sense. The results of the present single-case study invite us to discuss about what is being done in relation to common nonspecific aspects, considering that these aspects seem to represent the main proportion of the actions carried out by the psychotherapists during a treatment.

The proposal is not to generate a new theoretical model based on those common nonspecific aspects but to identify them, study their function in the different psychotherapeutic contexts represented by each theoretical framework, and their interaction with the specific components of each theoretical framework. An architectural model like this would study how these specific and nonspecific intra an extra theoretical framework are linked between them. Therefore, it would not go toward the direction of adding models that work together in different contexts.

Being that said, we should not follow the road that heads to integrating what is already common, but to think of a new architecture on which the associated common factors are boosted, with a greater efficacy in their interaction with some specificities. The true challenge lies on establishing the criteria to know which the specificities with potential therapeutic success are, and which of them are viable of being integrated.

Criteria such as that presented by Lazarus (2005) in relation to prioritizing the results of investigations that use RCTs as a standard of decisions to shape psychotherapeutic treatments, do not end up defining which is the basis for the selection of the models to be contrasted through such studies, and even more important, which is the basis to synthesize the information of the different RCTs' results that, as various meta-analysis show (Wampold, 2001), many times contradict each other, and require to build-up interpretations on the results' differences.

Based on this previous idea, it is necessary to plan an agenda that allows the psychotherapists to incorporate the information coming from different sources (not only RCTs' inputs) in order to choose the strategy

that will lead a long-term process of integration. It is understood, of course, that generating a new architecture for psychotherapy in global terms, whether it is from an integrationist position or not, could imply the abandonment of nodal concepts of existing theories, making place for new concepts and interactions.

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